DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
DIVISION OF LONG-TERM CARE

REQUEST FOR ENROLLMENT IN MONEY FOLLOWS THE PERSON PROGRAM

Participant Name:	
Medicaid ID Number:	
Case Manager/Transition Coordinator	
Provider ID Number:	

Medicaid Waiver Type: (check the appropriate waiver box)

☐ AIDS ☐ EDCD ☐ IFDDS ☐ MR/ID ☐ TECH

Criteria: (Check each item as it is discussed with Participant.)

☐ Participant has given consent to participate in Money Follows the Person Program.

☐ Participant is a resident of the Commonwealth of Virginia;

☐ Participant has been living in a long-term care institutional setting, a Nursing Facility, Long-Stay Hospital, or Intermediate Care Facility for Individuals with Intellectual Disability/Mental Retardation for at least six successive months, including periods of hospitalization;

☐ Participant is eligible for Medicaid at least one month at the time of transition or already has Medicaid.

☐ Participant is transitioning to a "qualified" residence; (check only one box)

- ☐ A home that they or their family member owns or leases;
- ☐ An apartment with an individual lease, with lockable entry and exit, which includes living, sleeping, bathing and cooking areas over which they or their family has domain and control; or
- ☐ A residence, in a community-based residential setting, in which no more than four unrelated individuals reside.

☐ Participant has received a copy of the Money Follows the Person Project Guidebook on _____ (Insert date copy was provided.)

By submitting this request for enrollment the Transition Coordinator or Case Manager acknowledges that all criteria listed above have been met.

By submitting this enrollment request, the Transition Coordinator or Case Manager:

1. Attests that this applicant to the MFP program can reside safely in the community based upon the assessment and service plan developed during the transition process as required for enrollment into a Medicaid waiver.
2. Assures that there is documentation for all criteria listed above and the information is available in the Participant's record for review.

_____

SIGNATURE – Case Manager or Transition Coordinator Date Signed